FOOT + ANKLE SPECIALTY CENTERS, LLC

Physicians & Surgeons of the Foot & Ankle

PATIENT'S NAME_____
(Please Print) LAST FIRST MIDDLE DATE OF BIRTH

HOME ADDRESS_____ CITY _____STATE_____ZIP _____

RACE/ETHNICITY: ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ MEXICAN AMERICAN INDIAN☐ WHITE/CAUCASIAN☐ OTHER☐

SEX: M☐ F☐ MARITAL STATUS: M☐ W☐ S☐ D☐ SOCIAL SECURITY#_____-_____-_____

HOME PHONE (___)_____CELL PHONE (_____)_____WORK PHONE (_____)_____

PLEASE PROVIDE **EMAIL** FOR BETTER SERVICE_____PATIENT EMPLOYED BY _____

RESPONSIBLE PARTY (INSURED)_____RELATIONSHIP_____DATE OF BIRTH_____

SPOUSE/PARENT NAME _____EMPLOYED BY _____DATE OF BIRTH_____

PRIMARY INSURANCE _____SUBSCRIBER'S NAME _____

ID# _____GROUP#_____

SECONDARY INSURANCE._____ID# _____GROUP# _____

PHARMACY NAME_____PHARMACY NUMBER (____)_____

WHOM MAY WE THANK FOR REFERRING YOU? (Doctor) _____

FAMILY PHYSICIAN _____DR.'S PHONE (____)_____

DR.'S ADDRESS _____CITY _____LAST VISIT _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____PHONE (____)_____

PREVIOUS TREATMENT BY PODIATRIST YES ( ) NO ( ) IF SO, WHEN _____

DESCRIBE TREATMENTS BY YOU OR ANY OTHER HEALTH PROFESSIONAL_____

_____

CHIEF FOOT CONCERN(S) (**DATE OF TRAUMA**)_____

_____

FOOT____ANKLE_____RIGHT_____LEFT_____BOTH_____**DURATION**_____

DESCRIBE PAIN (SHARP, DULL, SHOOTING, STABBING, ETC)_____

PAST ILLNESSES AND/OR OPERATIONS? _____

MEDICATIONS YOU NOW USE _____

_____

ARE YOU IN GENERAL GOOD HEALTH? YES ( ) NO ( ) IF NOT, WHY? _____

IF YOU NOW OR HAVE HAD ANY OF THE FOLLOWING, PLEASE CHECK (X)

( )DIABETES ( )LOW BACK PAIN ( )ASTHMA ( )TAKING BLOOD THINNERS
( )ARTHRITIS ( )VARICOSE VEINS ( )LIVER TROUBLE ( )STROKE
( )HEART TROUBLE ( )TUBERCULOSIS ( )KIDNEY DISEASE ( )GERD/REFLUX/GI ULCERS
( )BLOOD PRESSURE ( )BLOOD DISEASE ( )RHEUMATIC FEVER ( )GOUT
( )EYE TROUBLE ( )HEART MURMER ( )HEPATITIS/HIV ( )OTHER _____

IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING PLEASE CHECK (X)

( )NOVOCAINE ( )PENICILLIN ( )FOODS ( )IODINE ( )LATEX
( )ADHESIVE TAPE ( )SULFA ( )MATERIALS ( )DRUGS/OTHER _____

I HEREBY GIVE MY PERMISSION TO THE PHYSICIANS OF FOOT ANKLE SPECIALTY CENTERS TO ADMINISTER TREATMENT AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY BASED ON MY DIAGNOSIS AND/OR TREATMENT.

SIGNATURE _____DATE _____

FOOT + ANKLE SPECIALTY CENTERS

Physicians & Surgeons of the Foot & Ankle
Phone: (480) 812-FOOT (3668) Fax: (480) 782-1290

FEDERAL HEALTH PRIVACY RULE

CONSENT FORM

PRIVACY RULE
The Federal Government has developed regulations in an attempt to ensure the health care privacy of patients. This means that we cannot use or disclose health information for the purposes of treatment, payment, or health care operations without your written consent. As part of these regulations, we are required to inform you how this office utilizes, shares, and protects the health care information that we collect. Attached is a copy of our office policy and further detail regarding the Federal Health Privacy Rule.

You may revoke this consent at any time, or you may request additional restrictions on how your health care information is used and disclosed for treatment, payment, and health care operation purposes.

I agree with the Health Care Privacy Compliance being utilized by this office.

DATE: _____

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____

EMAIL: _____

DO YOU HAVE:
LIVING WILL ?
SURROGATE DECISION MAKER ?

Who do you authorize to accept results and/or have information about your treatment and/or condition by phone/person:

1. _____
2. _____
3. _____

Gateway Professional Village
4915 East Baseline Road
Suite 121
Gilbert, Arizona 85234

Arizona Medical Plaza
1728 West Glendale Ave
Suite 100
Phoenix, Arizona 85021

Chandler Place
1600 West Chandler Blvd
Suite 120
Chandler, Arizona 85224

Care MD Plaza
4845 East Thunderbird
Suite 2
Scottsdale, Arizona 85254

FOOT + ANKLE SPECIALTY CENTERS

Physicians & Surgeons of the Foot & Ankle
Phone: (480) 812-FOOT (3668) Fax: (480) 782-1290

FINANCIAL POLICY

Dear Patient:

We would like to take this opportunity to welcome you to our practice to provide your foot and ankle care. We appreciate your trust and look forward to keeping your feet and ankles healthy and happy.

As part of our services, we try to contain the ever-rising cost of health care. To do this, we have implemented this ***Financial Policy*** which we ask you to read and sign. You may receive a copy of this policy for your records if you so desire. The original will be maintained in your medical record.

INSURANCE BENEFITS AND COVERAGE

As a courtesy to you, our staff will contact your insurance company to verify your coverage benefits regarding podiatric medical care. We will make every effort to advise you if certain treatments are not covered by your plan. In doing this, we must rely on the information provided to us by your insurance company representatives. We do document the person we speak to and the date of the call. However, we cannot be responsible if we are given false information by your company although this is rare. Verification of coverage and eligibility IS NOT a guarantee that payment will be made by your insurance company. That is determined by your insurance company at the time the claim is submitted and reviewed. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you ever have any questions regarding your coverage, we will be happy to assist you in obtaining the answers. Ultimately, YOU are responsible for all costs uncured during treatment, with the exception of PPO, HMO, or Preferred Provider adjustments and write-offs. These adjustments and write-offs are determined by the contracts we have with your insurance company.

CO-PAYMENTS AND DEDUCTIBLES

Although we accept assignment of insurance benefits as determined by our PPO, HMO, and Preferred Provider contracts with the various insurance companies and medical groups, we do require payment of co-payments, patient portion amounts, and any unpaid yearly deductible to be made at the time of service.

UNINSURED PATIENTS

FULL Payment is due at the time of service. We accept cash or check.

NONCOVERED BENEFITS

We realize unforeseen circumstances may arise or that some insurance companies, especially HMO's, may not cover some medically necessary services (i.e. orthotics). In these instances, a payment plan may be available. These will be evaluated on a case by case basis. While we try to accommodate all our patients, we do maintain strict guidelines regarding payment plans. Failure to adhere to the payment schedule will result in a revocation of the payment plan agreement.

BALANCES AND STATEMENTS

You will receive a statement at the end of each month. If any payment is due, the statement will have a "**Pay This Amount"** section on it. This payment is due by the fifteenth of the month. If this payment has not been received by the next billing cycle, a "**Rebilling**" fee of $15.00 (fifteen) will be added to your balance. This will be repeated each month. If you have difficulty making a payment, you MUST contact us PRIOR to the due date to avoid these fees.

In order to refrain from raising our fees, we must control our costs and maintain efficiency in the business aspect of the practice. We are dedicated to providing you and your family with the best possible foot and ankle care available. We will also attempt to accommodate you whenever possible. You have any questions regarding this ***Financial Policy*** or any other matter, please contact the office manager. Thank you for your understanding. We look forward to serving all you foot and ankle needs.

I, _____, have read this ***Financial Policy***, understand it, and agree to its terms.

Signature_____ Date:_____